State WISCONSIN

Methods and Standards for Establishing Non-Institutional Reimbursement Rates

General In accordance with Sec. 1902(a)(30) of the Social Security Act this attachment describes the policy and methods used in establishing reimbursement rates for non-institutional care and services provided by the state's Medical Assistance Program as iterated in Sec. 1905(a) of the Act. Reimbursement methodologies and standards for inpatient hospital care is found in Attachment 4.19A and, intermediate care and skilled nursing facilities, in Attachment 4.11D.

A. Reimbursement Limitations

1. In accordance with 42 CFR 447.200, payment for services is consistent with efficiency, economy and quality of care.

2. In general, the department will pay the lesser of a provider's usual and customary charge or a maximum fee established by the department. The maximum allowable fee is based primarily on the usual and customary charges submitted to the Medical Assistance Program, the Wisconsin State Legislature's budgetary constraints and other relevant economic limitations.

   The "usual and customary" charge is defined as the amount charged by a provider in the same service when rendered to non-Medicaid patients. If a provider uses a sliding fee scale for specific services, "usual and customary" means the median of the provider's charge for the services when rendered to non-Medicaid patients.

3. In no case will rate increases exceed those authorized by the Legislature and the Governor.

4. Provider rates are determined on an annual basis.

B. Audit - 42 CFR 447.202

The department ensures appropriate audit of records wherever reimbursement is based on cost of care or service, or based on fee plus cost of materials.

C. Documentation - 42 CFR 447.203

The department maintains required documentation of reimbursement rates and complies with the requirements regarding increases in reimbursement rates as described in 42 CFR 447.203. This information is available to HHS upon request.

D. Provider Participation - 42 CFR 447.204

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1. The Reimbursement Methodologies are designed to enlist program participation by a sufficient number of providers so that MA recipients are assured that authorized medical care and services are available to the same extent those same services are available to the state's general population.

2. Program participation is limited to providers who accept as reimbursement in full the amounts paid in accordance with the rate methodology, or to providers who enter into contracts with the department to provide services for free or at a reduced reimbursement level.

E. Public Notice

In accordance with 42 CFR 447.205, the department will post public notice in advance of the effective data of any significant proposed change in its methods and standards for setting reimbursement rates.

F. Methods and Standards for Establishing Payment Rates for Non-Institutional Care

The Department will establish maximum allowable fees for the covered services listed below. Maximum fees may be adjusted to reflect reimbursement limits or limits on the availability of federal funding specified in federal law. For each covered service, the Department shall pay the lesser of a provider's usual and customary charge or the maximum fee established by the Department.

*1. Physician Services
2. Chiropractic Services
3. Early and Periodic Screening, Diagnosis and Testing (ESD)
4. Medical Day Treatment, Mental Health and AODA Counseling (except Physician Services)
5. Optometrist/Optician Services
** 6. Private Duty Nursing Services
7. Transportation Services
*** a. Specialized Medical Vehicles
b. Ambulance
8. Laboratory and X-ray Services
9. Blood Banks
10. Dental Services
11. Audiology
12. Occupational Therapy
13. Speech Therapy
14. Physical Therapy
15. Family Planning Clinics
*16. Nurse-Midwife Services
17. Ambulatory Surgical Centers

1. Physician Assistant Services

Reimbursement for physician assistant services is made at a percentage of a physician's payment for each specific procedure. Specifically, the physician assistant maximum allowable fee is based on 90 percent of a physician's maximum allowable fee for that procedure. Physician assistants are paid at a percentage of physician fees because they have less training, require physician supervision under state licensure, have a limited scope of practice and lower overhead costs.

Increased reimbursement is to encourage Medical Assistance Program participation by physician assistants who provide quality basic level care at a lower-cost than physicians.

Effective 7-1-93

2. Hearing Aids and Supplies

The Department will establish maximum reimbursement rates for all covered dispensing services, equipment and supplies. Providers will be reimbursed up to a maximum allowable dispensing fee and the next cash outlay cost to the provider of the materials and supplies purchased. "Net cash outlay cost" is defined as the actual cost to the provider to permit the provider to fully recover his out-of-pocket cost for the purchase of the hearing aid package furnished to WMAP recipients.

3. Drugs (Pharmacy)

The Department will establish maximum reimbursement rates for all covered pharmaceutical items and disposable medical supplies provided to Medical Assistance recipients.

All covered legend drugs will be reimbursed at the lower of estimated acquisition cost of the drug plus a dispensing fee or the provider's usual and customary charge.

Estimated Acquisition Cost (EAC) of legend drugs will be determined based on the following:

1. EAC for generic drugs and all multiple source drugs included in Addendum A of the Federal Upper Limits List will be determined by the Department such that total expenditures do not exceed the Federal aggregate limit for these drugs.

2. EAC for drugs where manufacturers make drug products directly available in reasonable volume to all pharmacies may be determined at the direct price, except for schedule II controlled substances which will be determined at the undiscounted AWP as listed in the First Data Bank Blue Book.

3. EAC for <u>other drugs</u> will be based on the Department's determination of the price generally and currently paid by providers for each drug sold by a particular manufacturer or labeler in the package size most frequently purchased by providers. This will be determined by applying a ten percent (10%) discount to the AWP as listed in the First Data Bank Blue Book, except for schedule II controlled substances which will be determined at the undiscounted AWP.

All allowed drugs costs will be calculated based on the package size from which the prescription was dispensed, as indicated by the package NDC number. Rare exceptions may be made where state or federal minimum package sizes are specified and/or where WMAP assigned procedure codes are used.

Maximum allowable fees for covered over-the-counter drugs will be established as the estimated acquisition cost, plus a standard percentage markup as defined by the Department.

Multiple levels of dispensing fees will be allowed based on time and complexity of the professional activity. The maximum allowed reimbursement for each level of dispensing fee will comply with 42 CFR 447.331 and will be determined based on the following:

a. Professional time based on statewide survey of pharmacists' salaries.

b. Complexity of the activity required for dispensing the drug based on National Council of Prescription Drug Plans (NCPDP) standards and Wisconsin experience.

c. Allowed pharmacy overhead costs, such as materials, bottles, labels, rent, heat, lights, non-professional salaries.

d. Other relevant factors.

4. Vision Materials

Materials not covered under the Vision Care Volume Purchase Contract will be reimbursed at no more than the average wholesale costs of the materials.

5. Medical Supplies and Equipment

The Department will establish maximum allowable reimbursement rates for all covered disposable and durable medical supplies and equipment. Maximum rates for durable medical equipment shall be based on a review of various factors such as usual and customary charges, costs and other relevant economic and reimbursement limitations.

Maximum rates for other disposable medical supplies, except disposable diapers, shall be based on estimated acquisition cost (EAC) of the supplies plus a percentage markup as determined by the Department. EAC is based on: cost, payment and charge information from Wisconsin Medical Assistance Program, from companies that provide disposable supplies and from other sources such as other states' Medicaid payments; and Wisconsin State Legislature's Medical Assistance budgetary constraints.

The Department will establish maximum allowable fees for disposable diapers based on: cost, payment and charge information from Wisconsin Medical Assistance Program, from companies that provide disposable diapers and from other sources such as other states' Medicaid payments; and Wisconsin State Legislature's Medical Assistance budgetary constraints.

Effective 2-1-94

6. Rural Health Clinics

Claims for Rural Health Clinic (RHC) services are reimbursed by Wisconsin Medicaid on a fee-for-service basis at the lower of:

- The provider's usual and customary fee; or
- Medicaid's maximum allowable fee.

In addition to fee-for-service reimbursement, all RHCs, other than such clinics in rural hospitals with less than 50 beds, that complete a cost report are eligible to receive interim payments with final settlements based on 100% of reasonable costs, up to a maximum limit as established or allowed in HCFA publication 27, RHC and FQHC Manual, Chapter 505.1.

RHCs in rural hospitals with less than 50 beds that complete a cost report are eligible to receive interim payments with final settlements based on 100% of reasonable costs as determined according to Medicare cost reimbursement principles. This provision is effective for final settlements completed on or after October 1, 1998, for services provided on or after January 1, 1998.

RHC reasonable cost payments are made on a per encounter basis by ascertaining the average cost per day, per provider, per recipient at the RHC. An encounter is defined as a face-to-face encounter between a recipient and any Medicaid physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist or clinical social worker.

Effective 7-1-96

7. End Stage Renal Disease

(The Department shall pay the lesser of the provider's usual and customary charges or a maximum rate established by the Department.)

All covered legend drugs associated with this service shall be reimbursed at the lower of the provider's usual and customary charge, or the estimated acquisition cost of the product plus a dispensing fee. Reimbursement for certain multi-source drugs may be subject to federal or state maximum acquisition cost (MAC) limits. Drug prices are to be calculated based on the package size from which the prescription was dispensed as indicated on the NDC number. The only exception are those drugs for which quantity minimums are specified by federal regulations.

8. Case Management Services
EPSDT

Providers are reimbursed by a flat fee which is a percentage of the provider's average cost, established by the Department.

Effective 4-8-86

9. Case Management Services
Community Care Organizations

For case management services performed by Community Care Organizations, reimbursement will be made through the per diem rate as established by the department.

Certified providers will be reimbursed upon submission of an appropriate claim form, documenting recipient eligibility and services provided. This is true for all other MA-certified providers. Payments made from Title XIX funds for MA eligible clients will be appropriately matched with state and local funds, and will not duplicate other federal or state payments or match requirements.

Effective 10-1-86

10. Case Management Services
All Other Target Populations

Providers are reimbursed at a uniform statewide contracted hourly rate for each hour of allowable assessment, case planning or ongoing monitoring services. The rate is based on the statewide average rate for a social worker with annual increases based on the Consumer Price Index.

Effective 7-1-93

11. Home Health Services

The maximum fee schedule is based on the Medicare cost reports filed with the fiscal intermediary, Blue Cross/Blue Shield United of Wisconsin by each home health agency. The fiscal intermediary took the cost per visit from the settled Medicare cost reports for state fiscal year 1990 and brought these costs to the common period of June 30, 1990. The costs were further adjusted for inflation to 1992. These rates were arrayed by discipline from high to low. A maximum fee per visit, per discipline was set so that 58% of the certified home health agencies have their Medicaid costs met.

Eff. 6-29-96 Payments will be made at the lesser of usual and customary agency charges, or maximum allowable fees. These rates include travel, recordkeeping, RN supervision and other administrative costs as well as direct care expenses. In comparing established rates-per-visit to inflated costs, it is anticipated that some agencies may receive reimbursement equal to or exceeding their individual anticipated costs per discipline. It should be noted that at no time will an agency be reimbursed more than its usual and customary fee or the WMAP maximum rate, whichever is less.

12. Hospice Care Services

A "hospice cap" or maximum amount will be established by the Department for aggregate payments made to a hospice provider on behalf of all MA recipients enrolled in that hospice during a hospice cap period. The Department will also establish room and board rates to reimburse a hospice for those recipients enrolled in hospice who are residing in a nursing home.

Per diem rates shall apply for each MA enrollee for routine home care, continuous home care, inpatient respite care and general inpatient care. For continuous home care provided for more than 8 or less than 24 hours, hourly rates will apply. These rates will be those set by the federal Health Care Financing Administration.

Effective 7-1-88

Room and Board rates are determined in accordance with s. 1902(a)(13)(D), of the Act, as amended by sec. 6408 of OBRA '89.

The state adjusts per diem rates each year commensurate with federal Medicare rate increases upon notification from the federal Health Care Financing Administration.

Effective 1-1-91

13. Respiratory Care Services

Providers are reimbursed at statewide hourly rates for services performed by an RN, LPN or respiratory therapist. These hourly rates are established by the Legislature in statute.

Effective 7-1-97

14. Medicare Part B Coinsurance Payment

Payment is limited to the MA maximum allowable fee or rates, less the Medicare payment for a service provided to a recipient who is eligible for both Medicare and Medical Assistance. For Medicare services not otherwise covered by Wisconsin Title XIX, reimbursement will be established at Medicare rates.

Effective 7-1-89

15. Health Personnel Shortage Area (HPSA) Reimbursement for Primary Care Services

Physicians with primary care specialties and mid-level health professionals who practice in or provide primary care services to recipients residing in Health Personnel Shortage Areas (HPSAs) receive an incentive payment of 20% over and above the maximum allowable fees paid by the Medical Assistance Program for primary care procedures. A HPSA is a medically underserved area designated by the United State's Department of Health and Human Services under the Public Health Service Act.

The components of this benefit are:

- Primary care physicians have specialties in pediatric, general practice, family practice, internal medicine, emergency medicine, obstetric and gynecology;

- Mid-level health professionals are physician assistants, nurse practitioners and nurse midwives; and

- Primary care services are evaluation and management office, emergency department and preventive medicine procedures, immunizations and selected obstetric procedures.

When obstetric services are provided by the primary care physicians and mid-level health professionals these providers will receive an additional HPSA incentive payment of 25% over the regular bonus amount.

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